THEMES & DEBATES

An Interview with Sir Michael Marmot

The Editors

In August of 2008 the WHO Commission on the Social Determinants of Health concluded its work with the publication of a report entitled: "Closing the gap in a generation: Health equity through action on the social determinants of health." The Commission's chair, Sir Michael Marmot, was kind enough to answer our questions about the Commission's recommendations. This interview was conducted by email in May of this year.

Social Medicine: We congratulate the Commission on its excellent work in bringing attention to the social determinants of health and the Commission's call for health equity. We appreciated the Commission's recognition that: "Social Justice is a matter of life and death." We were also happy that the Commission included representatives of civil society in their work. This was an important affirmation of democratic values.

When thinking about health inequalities people often use the analogue of the ladder to show how the gradient of worsening health outcomes affects all people in society except (presumably) those at the very top. Thinking about the ladder leads us to pose the following question: Is making the ladder shorter (i.e. reducing inequalities) the only approach to inequalities or is it possible to imagine making the ladder disappear entirely?

Sir Michael Marmot: All societies have hierarchies. It is not conceivable, therefore, to have a society with no ladder. The conceptual framework of the Commission on Social Determinants of Health leads us to think of at least two (linked) ways to address the relation between position on the ladder and health: act at the societal level to reduce social inequalities, and break the link between position in the social hierarchy and health.

The first argues for reducing the slope of the social gradient. To see this, suppose, just for a moment, that the ladder were defined on the basis of years of education. People who had three years or fewer had life expectancy of 50 years, those who had 13 years or more had life expectancy of 80 and the rest were ranged in between in a graded way: the social gradient in health. Now if we had a societal change so that everyone had at least 10 years of education, and better health followed as a result, the magnitude of health inequity would be reduced. We have reduced inequities by making the ladder shorter.

Sir Michael Marmot
Source: World Demographic Association (WDA)

The second looks at exposures and vulnerabilities linked to position in the hierarchy, rung on the ladder. This approach says, in effect, even if the ladder were untouched, we should work to make sure that it is not the case that if you are lower down you have greater chance of not having clean running water, sanitation, good nutrition, or decent employment and working conditions.

Social Medicine: Yet, if the problem is the ladder – and not the absolute positions on the ladder – does it make sense (both pragmatically and politically) to promote social programs that target just the people at the bottom? Shouldn't efforts to address the ladder deal with all of society?

Sir Michael Marmot: Divide this question in two. First, if relative position is important for health inequity rather than absolute differences between people, aren't we sunk? If, see my answer to question 1, there are always hierarchies won't there always be relative differences, and hence health inequities?

One answer to this is to draw on the insight of Amartya Sen who argued that relative differences in income translate into absolute differences in capabilities. It is not so much what you have but what you can do with what you have. In Sen's formulation capabilities are influenced by, for example, health and disability of the individual. Capabilities are also heavily influenced by the nature of society. Social conditions will determine what capabilities mean in practice.

This leads to the second part of the answer. Health follows the social gradient. Those second from the top have worse health than those at the top, and so on, all the way down the social hierarchy. Focussing on the poor seems an obvious step as they have the worst health problems. But if we are really to address health inequity, as represented by the social gradient in health, there must be action across the whole of society.

Social Medicine: The suggestions of the Commission: "Improve the circumstances in which people are born, grow, live, work, and age; [and] tackle the inequitable distribution of power, money, and resources—the structural drivers of conditions of daily life—globally, nationally, and locally" imply nothing less than a complete restructuring of the global economic system.

These sensible proposals, if acted upon by national governments, affect very powerful interests in the economic, political and symbolic arenas. These interests are the very ones calling the shots.

Is there any evidence that these bodies will heed the call of the Commission and will actually eliminate global health inequities in a generation? Aren't you asking them to go against their own economic interests?

Sir Michael Marmot: In the Ethics of the Fathers we find the quote: it is not incumbent upon you to finish the task but neither are you free to absolve yourself from it. Abraham Lincoln may well have been influenced by such teaching when he said: the probability that we may fail in the struggle ought not to deter us from the support of a cause we believe to be just. The Commission pointed to inequities in power, money and resources as being key drivers of health inequities. The fact that holders of such power may relinquish it with reluctance must not deter us from pursuing what is just. The Commission based its conclusions on the best evidence available. Vicente Navarro, among others, applauds the Commission's analysis and conclusions but says that what is needed now is political analysis and action. That does seem like an important next step. Change will only come about by collective action.

When we began the Commission I quoted from Martin Luther King's 'I have a dream' speech and said that we had to have a dream but we had to lay out practical steps to achieve it. Civil rights in the US have made great progress as the result of a strong social movement. There is a great deal further to go – if we needed evidence of that statement it is provided by the persisting health disadvantage of African Americans – and such progress will take political action. As it will in other countries and in the global sphere. Health statistics are listened to. The fact that, as we said in the CSDH report, social injustice is a matter of life and death needs continuously to be brought to the fore.

Social Medicine: Should the current international organizations be replaced by other, more democratic ones? Isn't the natural audience of the Commission's report those who are not in power?

Sir Michael Marmot: In 1942 in Britain, in the depths of the Second World War, Sir William Beveridge produced his report that laid the basis for the welfare state. In 1944, while the war was still raging, the Bretton Woods agreement laid the basis for the international economic architecture that dictated global economic policies in the whole post war period. The economic crisis that has engulfed the world is surely a time to say we can no longer tolerate business as usual. A meeting of the G20 is

inherently more democratic than the G7 or G8 but, really, we need a G193. All voices should be heard at the table.

Within countries, as well as globally, some governments are unwilling or unable to act. Civil Society has a vital role to play either to do the things that governments won't do or to complement government action. Our Thai colleagues talk of the 'triangle that moves the mountain': knowledge/academia, civil society, government. All are necessary and each is a natural audience of the report. This triangle does not obviously mention the private sector. It is easy to point to ways in which the private sector has been part of the problem – particularly in causing the financial crisis, in environmental effects, in employment and working conditions – can it be part of the solution?

Social Medicine: Given the deep historical and social roots of these inequalities was it realistic to call for eliminating them in a generation?

Sir Michael Marmot: We said quite explicitly that achieving health equity in a generation was not a prediction. We intended to convey two messages. First, start now with today's girls and boys, who are going to become mothers and fathers, and the circumstances in which their children are born and flourish, or not as the case may be. Put emphasis not only on child survival but on development – physical, cognitive/linguistic, and social emotional – and, in a generation there will be healthier cohorts of adults. Second, and it is related, we judge that there is no necessary biological reason why life expectancy in some countries should be less than 40 years and, in others, beyond 80. The Commission reached the conclusion that we have the knowledge and the means to make a huge difference to these inequities within and between countries. Let's not be demoralized by the resistance to achievement of health equity but be motivated to apply the knowledge we have. As above, civil society has a crucial role to play here.

Social Medicine: In 1978, Alma Ata called for 'Health for All.' What prevented us – at a global, national or sub-national level – from harnessing the evidence we had then into a comprehensive strategy to improve health? Is the political context more or less favourable now than in 1978?

Sir Michael Marmot: First, it has not been all disaster since 1978. Health as measured by life expectancy or child mortality, improved dramatically in every region of the world except sub-Saharan Africa over the last three decades. It is simply not the case that everything is going to hell. A 12.5 year improvement in life expectancy in South Asia in only thirty years is as welcome as it is dramatic. Second, there is a significant 'but': with life expectancy for women at 63 in India, why should it not be 86 as it is in Japan? Even more pertinently, why has life expectancy for women declined in some African countries? And, close to home for many of us, why are there widening health inequalities in so many of our countries?

The answers the Commission gave were in terms of the conditions of daily life and the structural drivers of those conditions: a toxic combination of poor policies and programmes, unfair economic arrangements, and bad governance. Is it more favourable to put those right than it was thirty years ago? Thirty years ago, those in power were not recognising the 'triangle that moves the mountain.' The analysis in the Civil Society Report to the Commission suggested that there was no triangle, only one angle: private sector good, public bad. And the third sector (civil society)? Goodness knows. The Commission drew on important voices that suggested that this solitary angle – the Washington consensus – was deeply flawed pragmatically and questionable ethically. In a sense, the experience of the 1980s and 1990s, in hollowing out the public sector, of rapidly growing economic inequalities, of lack of attention to the social determinants of health was a grisly experiment that has been shown not to work or at best to work most unevenly.

There is no question that the evidence is stronger now than it was in 1978 and, second, intolerance for the magnitude of economic inequalities is surfacing in unlikely places. In Britain, bankers have succeeded politicians and tabloid journalists as favourite hate figures, In the US, they talk of Main Street versus Wall St. As the public sector now has

to pay for the hubris of bankers and traders in financial roulette, those erstwhile masters of the universe who were thought to have been the architects of our economic fortunes, it is hard even for true believers to maintain that what we most need is further deregulation and weakening of the public sector. The invisible hand will not deliver public goods, and for wealth creation, we need both a regulated private sector and a healthy public sector.

There were leading economists, so convinced by their models, that they averred that even to discuss John Maynard Keynes was not intellectually respectable. Now we hear discussion of little else. Events, the failure of a deregulated economy to deliver economic stability, and the urgency of climate change, mean that we must think through our economic arrangements differently.

If those who care about health equity can make their voices heard, and here the point above about the importance of political analysis and action is highly relevant, then there is an opportunity to do things differently.

Social Medicine: The 1980's saw the World Bank inspired erosion of universal, free public services, a movement that seems to have only further aggravated health inequities. Do you favour such universal, free programmes in health?

Sir Michael Marmot: Someone has to pay for health services. But why should it be the poor and the sick? Poverty causes sickness. Sickness can cause poverty. Why then charge people caught in this vicious cycle for health care? All the evidence shows they cannot afford it. They will either go without or be forced into poverty. The Commission's report drew attention to 100 million people forced into poverty annually because of out of pocket health care expenditure. What was the argument for charging them at the point of use? That if they are going to be so careless as to get sick they damn well better pay for their stupidity? That unless they paid (money that they could not afford) they would not appreciate what they were getting? In Britain people do not pay to visit their GP but they do pay a prescription charge; do they value their pills more than they value their doctor? I doubt it.

Not only do I not begin to understand the argument for out of pocket expenditure for the world's poor, the evidence at country level suggests that the greater the share of health care expenditure that is private the worse the health adjusted life expectancy. Colleagues in Switzerland argue that – provided there is universal coverage of health insurance – provision could be private. Perhaps. In Britain Julian Tudor Hart has made the point that the National Health Service, free at the point of use, is an expression of social capital. It not only delivers near to universal access, regardless of ability to pay, it is a manifestation of social cohesion.

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